**DRAFT - print date - 12/30/03, 1:39 PM**

# IOWA MEDICAID

# IOWA PLAN FOR BEHAVIORAL HEALTH

## Proposal for a Section 1915(b) Capitated Waiver Program Waiver Renewal Submittal

## May 2003

# Section E. FRAUD AND ABUSE

### Section E. FRAUD AND ABUSE

States must promote the prevention, detection, and reporting of fraud and abuse in managed care by ensuring both the State and the MCOs/PIHPs/PAHPs have certain provisions in place.

#### Previous Waiver Period

**a.** [Required for all elements checked in the previous waiver submittal] Please provide summary results from all fraud and abuse monitoring activities, including a summary of any analysis and corrective action taken, for the previous waiver period. [Reference: items E.I-II of 1999 initial preprint; relevant sections of 1995 preprint, item E.I Upcoming Waiver Period, 1999 Waiver Renewal Preprint)]

**RESPONSE:**

- **During the previous waiver period, the State's Medicaid fraud staff provide the PIHP with notice of disciplinary action taken regarding eight mental health or substance abuse providers potentially in the PIHP's network. The PIHP identified that none of the providers were actively participating in the PIHP network at that time.**
- **The PIHP initiated action in response to three findings of potential**

**inappropriate billing by network providers. In each situation, the PIHP initiated review of the provider's billing practices due to questionable documentation discovered by the PIHP's on-sight retrospective clinical review. The providers was cooperative, claims payment issues were resolved, the overpayments were corrected and the PIHP provided appropriate technical assistance. The PIHP reported the incidents and follow-up action to State during weekly oversight meetings and State passed the information to the State's fraud unit for their review.**

- **The PIHP was contacted by the Office of the Auditor of State requesting information pertaining to a network provider under review. The PIHP provided the requested information. State was notified by this action by the auditor and by the PIHP.**
- **The PIHP was contacted by the a county auditor pertaining potential mishandling of funds by a network provider. The PIHP provided the requested information. State was notified by this action by the PIHP.**
- **The State notified the PIHP of the September 4, 2001 letter notifying State concerning the resolution by CMS of action pertaining to an Iowa hospital. In this situation, the hospital did operate a mental health program and was not a network provider.**

**Upcoming Waiver Period** -- Please check all items below which apply, and describe any other measures the State takes.

## I. State Mechanisms

**a. _X_** The State has systems to avoid duplicate payments (e.g., denial of claims for services which are the responsibility of the MCO/PIHP/PAHP, by the State's claims processing system).

**RESPONSE:**

**State requires the Medicaid fiscal agent to edit Medicaid fee-for-services claims to assure that Medicaid FFS does not pay for Medicaid mental health or substance abuse services for Iowa Plan enrollees for when those services are covered under the Iowa Plan.**

**b.___** The State has a system for reporting costs for non-capitation payments made in addition to capitation payments (e.g., where State offered reinsurance or a stop/loss limit results in FFS costs for enrollees exceeding specified limits)

**c.___** The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in the managed care program in this waiver, which identifies the staff, systems, and other resources devoted to

this effort. Please attach the fraud and abuse plan.

**d._ X_** The State has a specific process for informing MCOs/PIHPs/PAHPs of fraud and abuse requirements under this waiver. If so, please describe.

**RESPONSE:**
**The contract section 21 specifies fraud and abuse requirements.**

**e.___** Other (please describe):

## II. MCO/PIHP/PAHP Fraud Provisions

**a.___** [Required for MCOs/PIHPs if State payments based on data submitted by MCO/PIHP, e.g. encounter data] MCO/PIHP must certify data as follows:

(i) data is accurate, complete, and truthful based on best knowledge, information, and belief

(ii) certification is made by plan CEO, CFO, or individual delegated to sign for, and reports to, plan CEO or CFO

(iii) certification is submitted concurrently with data

**RESPONSE:**
**Not applicable because capitation payment is not based on PIHP's encounter data.**

**State requires an external review and verification of levels of performance which are subject to financial incentives and penalties.**

b. **_X_**[Required for MCO/PIHPs]The State requires MCOs/PIHPs to have an internal plan for preventing, detecting, and pursuing fraud and abuse. Plan includes:

(i) **_ X _**Written polices that articulate commitment to comply with all applicable Federal and State laws

(ii)___Designation of compliance officer and committee

(iii)___Effective training and education for compliance officer and plan employees

(iv)___Enforcement of standards through well-publicized disciplinary guidelines

(v)**_ X** Provision for internal monitoring and auditing

(vi) _ **X** Provision for prompt response to detected offence, and corrective action initiative related to MCO/PIHP contract

**RESPONSE:**

**Section 21 of the contract requires the PIHP to promptly investigate reports of suspected fraud and abuse by employees, subcontractors, providers, and others with whom the Contractor does business.**

**The PIHP is required to have in place a method to verify whether services reimbursed by the Contractor were actually furnished to eligibles and members as billed by providers.**

c. _ **X** [Required for MCOs/PIHPs/PAHPs] The plan is prohibited from having affiliations with an individual who is, or who is affiliated with, an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation.

d. _ **X** The State requires MCOs/PIHPs/PAHPs to report suspected fraud and cooperate with State (including Medicaid Fraud Control Unit) investigations.